STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K070	A. BUILDING _____ B. WING _____	C 06/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TMG HOME HEALTH CARE INC	108 N MAIN STREET STE 305 SOUTH BEND, IN 46601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This visit was for a federal home health complaint investigation. Complaints: IN00108689- Unsubstantiated: Lack of sufficient evidence. Survey Date: June 29, 2012. Medicaid #: 201022100 Facility #: 011556 Number of records reviewed: 3 active records. Surveyors: Janet Brandt, RN, Public Health Nurse Surveyor TMG Home Health Care Inc. was found to be in compliance with 42 CFR 484.10, 484.18, and 484.30 as related to this complaint. Quality Review; Linda Dubak, R.N. July 6, 2012	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE